

## **INVOLUNTARY TREATMENT ACT QUESTIONNAIRE**

January 16, 2007

***Washington State permits civil commitment of a person with mental illness if he or she is “gravely disabled,” which is defined in statute as a person who is “in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety” or manifesting “severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.”***

### **1.a. What about this definition works to support the policy objectives of this review?**

- Missing the point. Need to seriously examine what you are doing to people when they get there. Move away from the medical model.
- “in danger of .... harm” Protecting the consumer from self or others when ill---essential
- “severe deterioration ..... functioning” Once consumer has decompensated assistance is required to return to previous level of functioning
- An appropriate continuum supports commitment when consumer is in danger of harm, has deteriorated in level of functioning and for safety reasons
- It supports protection and protection rights
- It is an inconclusive definition

### **1.b. What doesn't work?**

- It makes no statement that individual environment should not be a decision factor
- Way too broad definition
- What happens if “receiving care” but it is not sufficient?
- What about if the person isn't “gravely disabled” but rather in a state lacking appropriate coping abilities?
- Why would harm only result from a failure in service delivery?
- There is no reference to potential risk of harm to others
- Elimination of bed quotas and fines/corrective actions
- Perceived resources not broad enough
- Mental illness vs. mental disorder
- If not hospitalized, “receiving such care as is essential for his or her health and safety” --- this can be viewed too quickly as a scapegoat for not receiving more intense and truly sufficient care. Peer support needed.
- DDD not protected
- Disregarding other people's humanity
- Way too broad of definition
- It makes a statement that the individual environment should not be a decision factor
- MH calls that law enforcement receives far exceeds capacity of crisis teams

### **1.c. What would you change and why?**

- Nothing
- Narrow definition of gravely disabled and mental disorder
- More caregivers that are capable of handling “mental illness” without the need for forced medication
- Creating services in community to keep MH consumers in community, not jail or hospitals
- Supportive Centers----Clubhouses, NAMI
- 1290 and Title 19 teams---funding streams for case management for ongoing care, ineligible or not
- Gains Intercept model should be implemented
- CIT as first contact (First responder, jail diversion, release)
- Getting work groups together statewide
- Information distribution

***Washington State’s involuntary treatment law defines “mental disorder” to include “any organic, mental, or emotional impairment which has substantial adverse effects on a person’s cognitive or volitional functions.”***

### **2.a. What about this definition works to support the policy objectives of this review?**

- ITA defines what constitutes a person who is committable
- Does support an efficient use of public resources
- Misses the point of helping others
- Again, protection
- I think that the language is good. It captures a scope of potential disablements and it is objective regarding the effect of those disablements.

### **2.b. What doesn’t work?**

- People committed to facilities that usually aren’t designed to treat traumatic brain disorders
- Limiting to psychiatric model
- Does not support the first four policy objectives
- Serves as a safety net for individuals with developmental disability and dementia
- People committed to facilities that really aren’t designed to treat traumatic brain disorder
- The range of implementation and application too broad. Needs some conformity statewide.

### **2.c. What would you change and why?**

- The splitting of funds collected from RSNs that are over quota and should go to research. Why RSN under quota has keep consumers in community---what refund? Apply it in over quota RSN.

- Have specialized facilities for TBI, dementia and DD
- Consumer run services

***In Washington State, the age at which a person can voluntarily seek, request, or terminate inpatient mental health treatment is 13. However, a minor may be admitted into an inpatient or evaluation and treatment facility for an evaluation at the initiation of his or her parent. If the professional conducting the evaluation determines that inpatient treatment is medically necessary, a minor may not be discharged based solely on his or her refusal to accept treatment.***

### **3.a. What about these laws work in the best interests of children and families?**

- Children and family may have different needs
- Protects kids
- They provide a forensic option in the care of a minor exhibiting disabling/harmful behaviors

### **3.b. What doesn't work?**

- The absence of consistent supportive community based programs in each county
- Focus on birth date (13 years) without consideration of mental, social, intellectual ability/development level assumed to be achieved at age of 13
- Current statute that allows parents to admit their patients to inpatient is not a good thing
- Doesn't help each person
- Assumes parents have ability, best interest of child to ask for evaluation---this is a big assumption for dysfunctional or families in crisis

### **3.c. What would you change and why?**

- Need more support for families
- Disparity here. Feel there should be support for the parents separate from the children. Third party intervention needs to be in place to evaluate.
- Develop or validate a tool that can be applied that measures maturity of respondents that is not dependent on a chronological age benchmark.

### **4. What other issues or concerns related to Washington's involuntary treatment laws are important to you?**

- Discharge planning, esp., to line up funding
- If services are not appropriate---revolving door
- Informational silos---continuous quality services
- Statewide approach to policy, esp., with corrections and medical
- Increased negative behavior, decompensation, training inadequate
- Keeping consumer in community without arrest
- Advance Directives

- Peer advocate
- Quality of care
- Voluntary access to treatment, even if it is voluntary treatment at state hospitals
- Stop using forced psychiatric treatment